Health Plan of San Joaquin | Mountain Valley Health Plan

Out of Network Provider Request Form

Read Instructions Carefully

Select which type of request is being made. Review for criteria and complete required elements in subsequent page(s).

1. Select Urgency:

☐ **Urgent** (Decisioned within 3 calendar days) –

Is there a risk of harm to member? "Risk of harm" is defined as an imminent and serious threat to the member's health.

☐ Yes ☐ No

☐ **Non-Urgent Routine with timeliness need** (within 15 calendar days)

If the member has a condition that requires more immediate attention, such as upcoming appointments or other pressing care needs

☐ **Non-Urgent Routine** (within 30 calendar days)

2. Select Reason for Out of Network Provider

☐ **Continuity of Care:** Continuity of Care is to allow continued care for members when the following criteria are met:

- The network that the participating provider works with stops providing services
- They recently joined a network where their current provider is not a participant
- The Provider is Medi-Cal Enrolled with DHCS
- The Provider is willing to engage in a contract for continuity of care

☐ **No In-Network Availability or Medical Necessity:** LOA due to no in network availability allows the members to access needed services when:

- The network provider does not have availability within access and availability and time and distance standards per DMHC and DHCS, **and**
  - Access and Availability of Appointment Standards[1,3]:
    - Urgent = 96 hours (with prior authorization)
    - Non-Urgent Mental Health Appointment (Routine) Non-Physician[2] = 10 business days
    - Non-Urgent Mental Health Appointment (Routine) Psychiatry = 15 business days
    - Follow-up Care Mental Health/Substance Use Disorder Follow-up Appointment (non-physician) = 10 business days from prior appointment
  - Time and Distance Standards[3]:
    - Mental Health (non-psychiatry) Outpatient (adult and pediatric) 30 miles / 60 minutes
    - Substance Use Disorder Outpatient Services 30 miles / 60 minutes
    - Substance Use Disorder Opioid Treatment Programs 30 miles / 60 minutes
- There are no in-network providers that can offer the requested specialty service, **Or**
- There is a medical necessity to see this out of network provider

3. Complete the Form Attached

When completing the form attached, ensure that you are including all of the necessary information to ensure that this can be processed timely. Some key elements are as follows:

- Provide date of request
- Name and contact information for requested provider.
- Type of service requested/specialty needed (therapy, psychiatry, etc.)
- Member ID #
- Billing provider and rendering details: TIN, NPI, Address, Phone #, License Type
- Language, cultural or other needs specified

[1]DMHC Timely Access to Care Standards (https://www.dmhc.ca.gov/HealthCareinCalifornia/YourHealthCareRights/TimelyAccesstoCare.aspx)
[2]Examples of non-physician mental health providers include counseling professionals, substance abuse professionals and qualified autism service providers
[3]DHCS Network Adequacy Standards – Attachment A (https://www.dhcs.ca.gov/formsandpubs/Documents/MMCDAPLsandPolicyLetters/APL2021/APL21-006AttA.pdf)

Out of Network Request Form

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1. Request Information			
Date of Request:		Requested by:	
Request Type:	☐ Continuity of Care ☐ Access/Availability of INN ☐ Specialty / Medical Necessity	Urgency:	☐ Urgent - Risk of Harm – ☐ Yes ☐ No ☐ Routine – Initial ☐ Routine – Follow-up
Specialty Needed:		Language / Cultural Need:	

2. Member Information			
Member's Name (First MI Last):		Date of Birth:	
Address:		City, ST, ZIP:	
Member's Phone Number:		Point of Contact:	

3. Health Plan Information			
Member ID:		Member CIN:	
Previous Plan Name:		Effective Date with Health Plan:	
Member's known Primary HealthCare Coverage:		Primary Health Plan Denial Letter Attached?	☐ Yes ☐ No

4. Requesting Provider Information			
Rendering Provider (First and Last Name):			
Rendering Provider NPI:		License type and Number:	
Billing Tax ID:		Billing NPI (if different than rendering NPI):	
Billing Address:		City, ST, ZIP:	
Service Address:		City, ST, ZIP:	
Phone Number:		Fax Number:	

5. Case Information	
Condition/diagnosis being treated (ICD-10 code, if available)	
Treatment (CPT code(s), if available):	
Frequency:	
Reason:	
Date of Last Appointment (if applicable):	
Date of Next Appointment:	
If Continuity of Care: Original Start Date with Provider:	

6. Additional Information to Be Considered:

Provider Signature _____ Date of Signature _____

Health Plan Staff Submitter _____ Date of Submission _____

Proud to be an NCQA Accredited Health Plan

Please email completed forms to:
Health Plan of San Joaquin / Mountain Valley Health Plan

For more questions, please contact us:

Mental Health Services	**Behavioral Health Treatment/Applied Behavioral Analysis**
Phone: 1-800-338-0030 8:00 a.m. to 5:00 p.m. Monday through Friday	**Phone:** 1- 800-549-2022 8:00 a.m. to 5:00 p.m. Monday through Friday
Email: BHCM@hpsj.com	**Email:** BHTReferral@hpsj.com
Fax: 209-762-4761	**Fax:** 209-762-4760